FIREARMS HEALTH CERTIFICATION FORM

I, *[Doctor's Full Name]* _____, *[Doctor's Medical License Number]* _____, a licensed and practicing physician in the field of *[Specialty]* _____, hereby certify that after conducting a comprehensive medical evaluation of *[Full Name of Applicant]* _____, *[Identification Card / Passport Number]* _____, and also having reviewed their medical history, **I find no current medical or psychological conditions that would impede their physical or mental fitness to keep and/or use a firearm.**

This certification is made in accordance with all applicable Maltese laws, regulations, and ethical standards governing medical practice. It is based on my professional judgment and expertise as a qualified medical practitioner. I affirm the accuracy and truthfulness of the information contained herein to the best of my knowledge and belief.

I also acknowledge that this certification will be used by the Malta Police Force as part of their assessment process for *[Full Name of Applicant]* _____ firearm license eligibility.

Signature: _____

Date: _____

This certification reflects the applicant's health status ***at the time of examination****.*

Rubber Stamp

DOCTOR'S FULL NAME, TITLE, AND CONTACT INFORMATION

[Name of Medical Practice, Clinic, or Hospital]_____

[Email Address] _____